benefit—whether this is an improvement in quantity or quality—seem to be excellent value. Those costing £10 000 for each year of benefit probably represent an unfair distribution of resources—a verdict likely to apply to many treatments costing between £1000 and £10 000 for each year of benefit. All treatments of debatable value need economic as well as thorough clinical assessment, and oncologists and their colleagues in the laboratory need to develop better ways of predicting which patients will benefit from them.

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In search of consensus

No agreement on who should write guidelines or how they should be used

Almost every month—or so it seems—a new consensus statement or set of guidelines is published attempting to specify the optimum management of some common condition. Some are drawn up by prestigious organisations such as the United States National Institutes of Health, the Rand Corporation, or the Royal College of Physicians while others emerge from ad hoc meetings by small self selected groups. In this world of consensus there is, however, no agreement on how guidelines should be created or by whom, nor on how doctors should be expected to react to them when they appear.

These questions were tackled at a recent meeting on expert groups organised by the King Edward's Hospital Fund for London. The common ground agreed by the participants was that there is good evidence that patients treated according to a defined protocol generally do better than those treated freehand by an individual doctor. How, then, should the protocols be established.

The first task, clearly, is for an individual or groups to review the relevant published material to ascertain what (if anything) has been established by well designed, properly analysed research studies. For most topics the published reports are, in the words of one expert at the meeting, "rich but often inappropriate." In the Rand Corporation model an exhaustive literature review is followed by filling in the gaps by discussions with clinicians. The organisers then construct a list of all the clinical features of potential patients for, say, coronary angioplasty (age, sex, blood pressure, history, features of the electrocardiogram at rest and during exercise, etc). A consensus panel of clinicians then looks at these indications in terms of clinical risks and benefits using first a Delphi procedure in which each participant scores the indications and then modifies his or her scores in the light of scores recorded by the others, and then a discussion session lasting one and a half days. At the end of this expensive and time consuming process the clinical indications are each scored on a rating of one to nine. The King's Fund meeting was told that when results obtained in this way are presented to clinicians who took no part in their preparation there is little disagreement about what care is appropriate for a patient with a particular clinical profile—though there might be less agreement about whether or not the care was necessary.

The Rand method puts the clinical indications under a microscope but does not attempt any judgments about costs or social priorities. At the National Institutes of Health and at the King's Fund consensus meetings the approach has differed in two ways: the published data have been reviewed using individual experts' assessments rather than a complete literature review, and the consensus panels have included non-medical experts and lay people and have tried to look at wider issues such as the affordability of a procedure and how it should be measured against other competing demands for medical resources.

During discussion all agreed that however a meeting to create guidelines was structured the clinicians who took part found the experience worthwhile as they began questioning their accepted patterns of practice and justifying them to colleagues. There was strong support, too, for having a chairman who, while medical (and thus familiar with the language and the concepts), had no special knowledge of the topic being examined. Ideally, the expert panel should separate what was reasonably certain from what was no more than informed opinion and should also identify the research topics that needed urgent attention.

Is it a good idea for small, local groups to attempt to produce guidelines of this kind? At very least the exercise itself may be expected to be both enjoyable and educational, and there is plenty of evidence that clinicians are much more likely to follow guidelines if they have played some part in creating them. Nevertheless, the King's Fund meeting seemed persuaded that it was a waste of time and money for hundreds of collections of doctors to meet to devise protocols for treating conditions such as hypertension or diabetes when so many good sets of guidelines already exist. What the meeting wanted to see was a few representative, national bodies drawing up basic guidelines: these could then be distributed around the country to local groups which could then discuss them, modify them to take account of local cultural and social features, and in so doing give the local clinicians the essential feeling of ownership of the management protocols.

And beyond treatment protocols? At the edge of the map there may be dragons—the whole new vista of assessing the outcome of treatment, measuring the effects of introducing a protocol, modifying it to take account of the findings, measuring the outcomes of the modified protocol—truly a process that will never (and should never) be completed.

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